Dermatology Department
Alison Lindsay-Beltzer, MD
Dorian Gravenese, MD
Jeffrey Goldstein, MD
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MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____

PAST MEDICAL HISTORY: Please check if you have a history of:

☐ Pacemaker	☐ Tuberculosis	☐ Congestive Heart Failure
☐ Artificial Joint (Hip/Knee)	☐ GERD (Reflux Disease)	☐ Heart Arrhythmias
☐ Artificial Heart Valve	☐ Irritable Bowel Syndrome	☐ Mitral Valve Prolapse
☐ HIV	☐ Stomach Ulcer	☐ Rheumatic Fever
☐ Hepatitis	☐ Osteoporosis	☐ Cataracts
☐ Thyroid Disease	☐ Diabetes Mellitus	☐ Glaucoma
☐ Allergies/Sinusitis	☐ High Cholesterol	☐ Cancer (other than skin)
☐ Asthma	☐ Hypertension	☐ Other Medical Problems
☐ Emphysema/COPD	☐ Heart Attack	_____

MEDICATIONS: *Please note: If your PCP is on SMG's medical staff, you do not need to list medications*

Medication (Currently Taking)	Taken For

Allergies to medication? ☐ YES ☐ NO **If yes, list:** _____

Females Only: Are you currently pregnant or actively trying to get pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

PAST MEDICAL HISTORY: Please check if you have a history of:

☐ Eczema ☐ Psoriasis ☐ Lupus ☐ Scarring Acne
☐ Skin Cancer ☐ Melanoma ☐ Basal Cell ☐ Squamous Cell
☐ Actinic Keratosis (Precancerous Skin Growth) ☐ Other _____

SOCIAL HISTORY:

Do you smoke: ☐ Yes ☐ No
Do you use tanning booths: ☐ Yes ☐ No
Do you wear sunscreen regularly? ☐ Yes ☐ No

FAMILY HISTORY: Please check if there is any history in your family of:

Skin Cancer ☐ Yes ☐ No Type: _____
Psoriasis ☐ Yes ☐ No
Eczema ☐ Yes ☐ No

PHARMACY INFORMATION:

Pharmacy: _____ Phone: _____
Address: _____